STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

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July 3, 2014

Allan J. Pinard
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Connecticut Hospital Association
110 Barnes Road
Wallingford, CT 06492

Dear Mr. Pinard:

Thank you for your May 28th letter regarding the new inpatient reimbursement system using all-patient refined diagnosis related groups (APR-DRGs) to be implemented effective January 1, 2015. Each of your questions is listed below, followed by the Department's response. The questions were answered to the best of our ability, recognizing that there are still decisions to be made. We expect additional information to be available for our update meeting on July 28th.

1. The transition is described as budget neutral at the hospital-specific level for some period of time. How many years is the state planning to keep the transition budget neutral at the hospital-specific level?
   Answer: DSS has committed to implement the system as revenue neutral for each hospital, and that initial implementation will include at least one year of payment. Once the DRG system has been implemented, DSS will use the increased transparency and the ongoing experience from modernizing the method of payment to begin a process to further rationalize the level of payment. At this time the duration of that process has not been defined.

2. After budget neutrality at the hospital-specific level ends, what is the year-by-year phase-in plan from hospital-specific to a state standard rate?
   Answer: At this time DSS has not developed a year-by-year phase-in plan. As discussed above, DSS plans to begin the analytical work to develop the desired end-state and phase in schedule beginning in early 2015.

3. How much of a blend (hospital-specific and state) is expected? Is the goal 100% standard, or is there a different standard?
   Answer: At this time DSS has not developed the desired end-state or standardized rate targets. DSS has considered many ideas and studied other state's approaches. As discussed above, this will be an important part of the work to be done in 2015.

4. Please provide an example demonstrating how budget neutrality at the hospital-specific level will be calculated.
   Answer: DSS is working with our vendors to finalize the decisions needed to finish the methodology this month. It is anticipated that the proposed methodology will be provided in early July and a walk through of this example will be presented at an upcoming stakeholder meeting, scheduled for July 28, 2014.

5. Will a settlement process continue to exist, and what reimbursement components will be settled?
   Answer: Many of the current supplemental payments and some of the line items of the current reconciliation will remain outside the APR-DRG system. Historical revenues included in the APR-DRG reimbursement system include:

   - **Current case rate payments**
   - **Capital**
   - **Burn units**
   - **Transplants**
   - **Physical Rehabilitation (for hospitals without Medicare distinct part unit reporting)**

   Revenues not based directly on APR-DRG payment but still paid concurrently or prospectively include:

   - **Physician payments for hospital based physicians (paid directly via physician billing on CMS-1500)**
   - **Indemnity payments (part of claims adjudication)**
   - **Organ acquisition costs**

   Revenues that were previously outside of the case rates or part of the reconciliation for which a similar process will exist:

   - **Graduate medical education — direct.**
   - **Supplemental payments (disproportionate share hospital, etc.).**

   DSS is still determining how behavioral health and physical rehabilitation services will be reimbursed.

6. To what contracted resources (vendors) has DSS committed for the ongoing maintenance of the new system?
   Answer: DSS anticipates that the current consulting team (Mercer-Myers and Stauffer) will maintain and update the DRG weights, grouper, rates, outlier thresholds, etc. DSS anticipates that HP will integrate initial and annual updates into their systems.

7. How frequently is DSS planning to update DRG weights, grouper, rates, coding, outlier thresholds, etc.? If DSS plans to update this information less frequently than once per year, please explain how DSS will handle the addition and deletion of annual codes. Please explain how DSS is planning to handle weight calibration.
   Answer: The DRG grouper (same grouper version) will be updated to handle new diagnosis and procedure codes according to updates released by the DRG grouper software vendor (as often as quarterly). DSS will update some of the other DRG system parameters on an annual basis (e.g. cost-to-charge ratios (CCRs), etc.). Timelines for updating DRG grouper versions, DRG relative weights, and hospital rates have not been determined at this point. Transitions to an ICD-10 native DRG grouper on

October 1, 2015, will require a new DRG grouper version but at this time it is expected that the DRGs and their relative weights will remain the same.

8. Since DSS is developing state-specific APR-DRG weights, of the 84,013 cases (slide 27) from 2012 to be coded as APR-DRG's, please provide a breakdown of the count of cases by APR-DRG and the criteria for determining sufficient volume for weight development.

Answer: A breakdown of the count of cases by assigned APR-DRG will be provided. The criteria used in determining sufficient claim volume for the establishment of a Connecticut Medicaid claims based DRG is shown below:

Minimum Sample Size for Stable DRG Weight

A test is done to determine the minimum number of claims required for a given confidence level that the true average DRG cost is within a desired range around the computed average from the claim set. The formula used for the number of claims, n, is:

$$N=((Z * S)/R)^2$$

Where **Z = confidence level**
S = standard deviation
R = acceptable range

For a DRG weight to be considered stable, the criteria used require a 75% confidence (Z = 1.15) that the true average is within ±15% of the computed average. Therefore, the formula becomes:

$$N = ((1.15 * \text{standard\_deviation})/(0.15 * \text{average\_cost}))^2$$

DRGs with less than 5 claims are automatically considered to be unstable DRGs.

9. Please describe the rationale for using cost versus charge weights, as well as any analysis that supports this choice.
Answer: Since hospitals have varying levels of cost-to-charge ratios (CCRs) a charge-based DRG would skew reimbursement toward those hospitals that have higher charges for the same services. A more equitable DRG weight is therefore based on estimated costs ensuring that reimbursement more closely matches estimated resource utilization (hospital cost). For this reason, Medicare has adopted cost-based DRG weights. From the Medicare 2014 Public Use File, Connecticut hospitals had CCRs from 0.039 to 0.878 with most hospitals within a range of 0.241 to 0.384.

10. Please describe the rationale for using state-specific weights given the size of the data set and blending with national weights, versus just using the national weights.
Answer: DSS rationale for using state-specific weights when claims volume is sufficient is to match reimbursement with hospital costs of services on an equitable basis. National standard weights would not provide as accurate a distribution of

reimbursement for a Medicaid population or for the actual costs incurred by Connecticut hospitals.

11. Does DSS have a contingency plan in case any component (e.g. weights, rates, coding, systems, etc.) is not defined fully or functional as of the target date?
Answer: DSS will continue with all current payment functionality until all the components of APR-DRG system are functional.

If you have additional questions, please contact Christopher LaVigne, at 860-424-5719.

Sincerely,

Kate McEvoy, Esq.
Director, Division of Health Services

cc: J. Jackson
S. Frayne
C. LaVigne